

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16744

State File No. _____

Registrar's No. **4684**

FILED JUN 4 1943

Registration District No. **313** Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County _____
(b) City or town **St. Louis, Missouri**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Childrens Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **One Week**
(Specify whether years, months or days)
In this community _____

3. (a) PRINT FULL NAME **ELGIN MADISON WHITLEDGE JR.**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **D**

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **August 8 1943**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
1 3 11 hr. min.

9. Birthplace **Gideon Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name **Elgin Madison Whittlede**

13. Birthplace **Gideon Missouri**
(City, town, or county) (State or foreign country)

14. Maiden name **One L. Thomas**

15. Birthplace **Gideon Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Elgin Madison Whittlede**

(b) Address **Gideon, Missouri**

17. (a) **Removal** (b) Date thereof **5/20/43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Malden, Missouri**

18. (a) Signature of funeral director **Albert H. Hoppe, Inc.**

(b) Address **4700 Washington, Blvd.**

19. (a) **J. F. Budeck** (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____
(c) City or town **Gideon**
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **19th**
year **1943** hour **10** minute **23 P.** M.

21. I hereby certify that I attended the deceased from **May - 19**
1943 to **May - 19** 19**43**
that I last saw him alive on **May - 19** 19**43**
and that death occurred on the date and hour stated above.

Immediate cause of death **Tuberculous Meningitis** Duration **Weeks**

Due to _____

Due to **14**

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

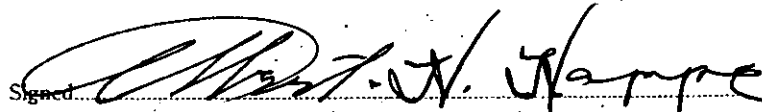
While at work? (Specify type of place) (e) Means of injury _____

23. Signature **W. B. Barnett** (M. D. or other) _____

Address _____ Date signed _____

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed 

Licensed Embalmer No. 1861

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.